With the people...

...For the people

Gonoshasthaya Kendra, Bangladesh

The People's Health Centre

ONE WORLD ACTION

FOR A JUST AND EQUAL WORLD

Mission Statement

One World Action is working for a world free from poverty and oppression in which strong democracies safeguard the rights of all people.

To this end, we provide money, expertise and practical help to organisations committed to strengthening the democratic process and improving people's lives in poor and developing countries. In all cases they initiate and work on the projects that we support, ensuring that local needs are genuinely understood and met.

As well as supporting our partners' work on the ground, One World Action represents their interests in Europe, putting forward their views in debates on policy towards poorer countries, and helping them to forge closer links with decision-makers in Britain and the European Union.

These 'partners for change' include other voluntary organisations, community and co-operative movements, women's organisations and trade unions. Though diverse in kind, they have a common commitment to strengthening local institutions and giving people a say in the decisions that shape their lives.

Central to our work is the belief that defeating poverty goes hand in hand with promoting human rights and good democratic government. Only if we pursue these goals in a coherent way can we build a just and equal world.

Policy Change Programme

One World Action's Policy Change Programme aims to inform and deepen the debate in the UK and at the European level on democracy, governance, rights and development issues. We publicise the work of our southern partners in building and strengthening democratic organisations, particularly at the local level, their engagement in local, national and international political structures, and their work for basic social, economic and political rights.

We have commissioned a number of in-depth profiles of some of our southern partners. These are analytical and constructively critical studies which examine the approaches and activities of each partner and the context in which they work. In particular, the profiles discuss how partners' approaches and activities strengthen democratic decision-making structures and promote greater gender equality and equity. We are publishing these profiles to contribute to development thinking by providing examples of 'good practice', and to document the views and experiences of our partners and the communities with which they work.

Cover: GK has been a key contributor to thinking about the way health services can be provided in a country with one doctor for every 30,000 people. Women paramedics can bring healthcare direct to the doorstep of the poorest people. *Picture: Jenny Matthews*

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by Tanja Haque

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Gonoshasthaya Kendra has been engaged in a partnership with One World Action dating back to 1990. GK is one of One World Action's largest partners. One World Action's main areas of support are GK's community health, education and disaster rehabilitation programmes including post rehabilitation work following the devastation of the 1991 cyclone and the floods in 1997, 1998 and 2000. One World Action has also contributed towards strengthening GK's lobbying and advocacy role notably the recent evolution of the People's Health Movement (PHM). GK's programmes reflect both organisations' strong commitment to gender equality and equity.

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1. The Bangladesh Context

Poverty in Bangladesh

Bangladesh is ranked as one of the poorest and most densely populated countries in the world. Bangladesh has a population of 130 million people and receives around US$2 billion per year in foreign aid. A decade ago the country was still around 90 percent dependent on foreign aid for its development budget. This has fallen over the last few years to about half the size.

The benefits of aid tend to fall mainly into the hands of a small urban elite consisting of bureaucrats, commission agents, contractors and consultants. The existence of elites has led to significant discrimination against the poor. For example, social programmes in health and education have suffered because they do not have strong interest groups to promote them.

Literacy rates for men and women in 2000 were 63 per cent and 49 per cent respectively and only about five percent of women are enrolled in technical and professional education. In addition, women's seclusion, sanctioned by traditional practices and beliefs, reduces mobility and limits women's employment opportunities.

Bangladesh has a very high level of landlessness[1] related to population growth and the fragmented landholding system. Growing poverty in rural areas and unequal land distribution drives many landless or land-poor households to migrate to urban centres, usually finding shelter in squatter settlements.

These trends have exposed women in particular to severe economic pressure. Life expectancy for women is lower than for men, with a sex ratio of 1.05 male/female. One of the reasons for the masculine sex ratio in Bangladesh is the high rate of maternal mortality (887 per 100, 000 births–World Bank 1997), an early start to childbearing and frequent pregnancies are the main reasons for this. Female malnutrition resulting from biased food allocation must also be taken into account.

World Trade Organisation policies have exposed local industries to greater competition from imports whilst not allowing them similar access to rich countries markets. Trans-national corporations have profited from lax regulation to corner the market in pesticides, hybrid seeds, agrochemicals and pharmaceuticals, adversely affecting the environment as well as people's livelihoods, health and food security[2]. World Bank imposed 'structural adjustment programmes' have resulted in drastic cuts in social expenditure particularly in the health and education sectors, reductions in public subsidies, public sector restructuring and a move towards privatisation.

Against this backdrop, donors began shifting their attention in the late 1980s towards non-governmental organisations (NGOs) rather than state initiatives in poverty reduction. NGOs target their resources more effectively, usually according to the criterion of landlessness.

Gender disparities

Mechanisms related to gender disparities within the context of a patriarchal society have affected women's lives in Bangladesh in a number of ways. As in several other South Asian countries, there is strong gender discrimination in access to health care, education and training, this is illustrated by the widely differing situations of men and women.

Private market forces have introduced women into the workplace in the last decade but in a gender-segregated way. Wages differ between men and women in various employment

sectors. Women's insufficient educational qualifications leave them with no other option than working in low-paid sectors of the labour market. Ninety per cent of the 800,000 workers in the garment manufacturing industry in Bangladesh are women. The majority of them are young and unmarried.

For a long time, however, various social groups in Bangladesh such as the state, market institutions and NGOs have shown an interest in women due in part to North American and European international donor policies. For example, in 1976, the government declared the reservation of 10 per cent of government posts for women. In the same year, besides the Social Welfare Sector, a new sector was created for women, known as the Women's Affairs Division. While the Social Welfare Sector of the state continued to provide welfare programmes for women, the Women's Affairs Division was tasked with the responsibility of promoting women's socio-economic status. In 1978, the Division was transformed into a full-fledged Ministry.

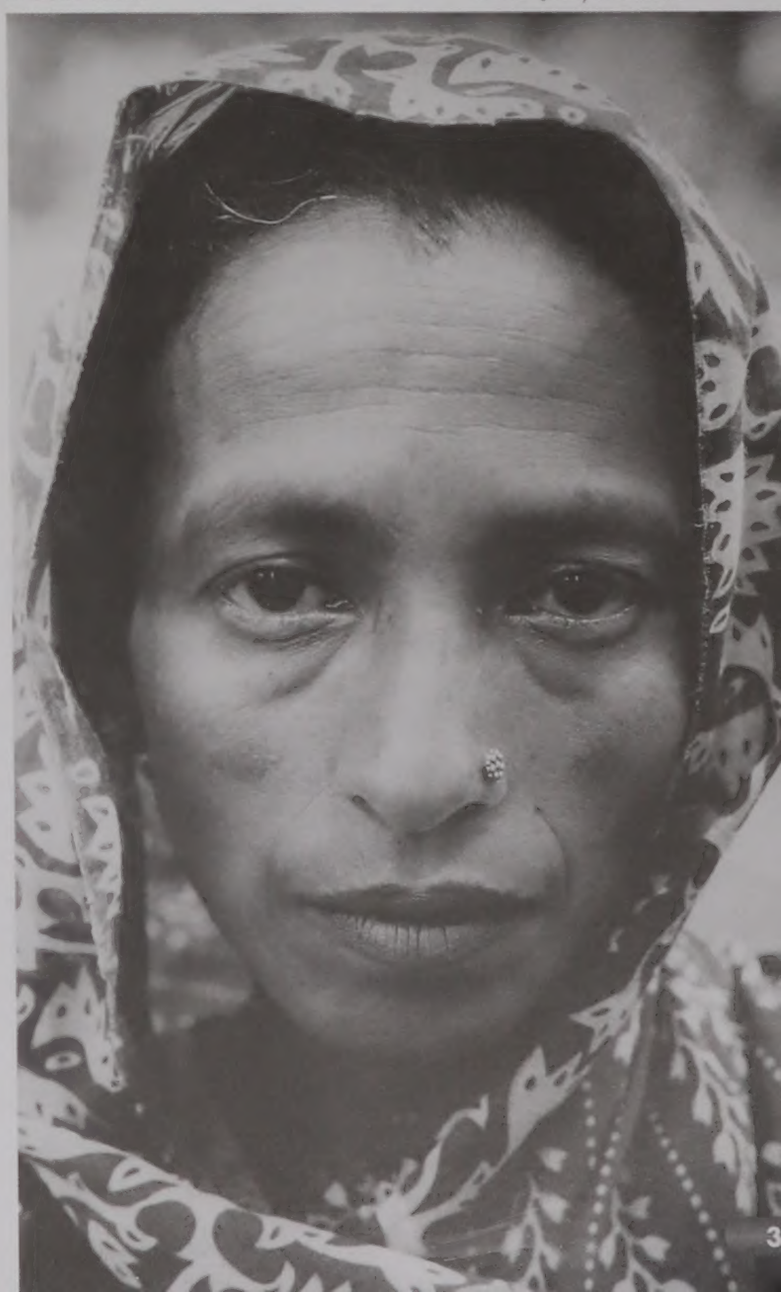
The role of NGOs

There has been a phenomenal rise in the number of NGOs since the inception of Bangladesh in 1971. In 1994, 16,000 NGOs were registered with the Directorate of Social Services, 1,600 with the Ministry of Women's Affairs and 850 with the Bureau of NGO Affairs (United Nations Development Programme 1994). Whereas in the early days NGOs were primarily involved in relief and rehabilitation work, they are now considered dominant actors in development intervention.

NGO activities largely centre around poverty reduction, women's rights, education, health, family planning and the environment. They also play a major role in the current discourse on good governance and civil society. Influenced by recent gender and development debates, many NGOs have identified women as their main target group. They reach approximately two million of the 65 million women in Bangladesh through projects such as credit and savings schemes, skills training, adult literacy, health education, family planning, legal awareness and consciousness raising[3].

Unfortunately many NGOs with a gender focus have concentrated on generating income for women within sex-stereotyped activities such as livestock and poultry raising, kitchen gardening, food processing and handicrafts. There are, however, a very small number of organisations that have applied innovative strategies of empowerment and that challenge the traditional gender division of labour. Their concern for women's position in society is not merely a response to recent donor influences, but has existed since the early 1970s. Gonoshasthaya Kendra (GK) is one of them.

Shanti Bala runs a tree nursery, which was started by GK, in Cox's Bazar. *Picture: Jenny Matthews*



2. Gonoshasthaya Kendra – History and Overview

History and context

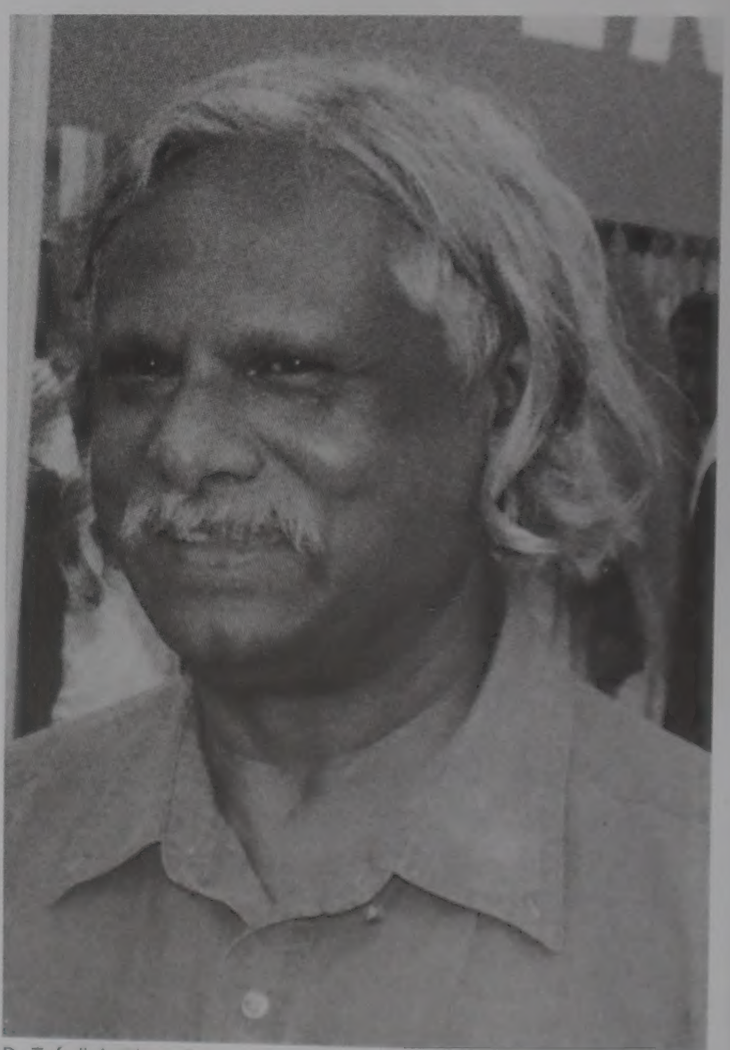
In 1971, during the liberation war against Pakistan, a few young Bangladeshi doctors were studying in the United Kingdom, amongst them Dr Zafrullah Chowdhury. They managed to mobilise money from Bangladeshi doctors all over the world to assist the freedom fighters[4] and returned to Bangladesh to set up a 480-bed field hospital on the Indian border for the wounded. After the war, in 1972, the hospital transferred to Savar, 40km north of the capital Dhaka. In the early 1970s Savar was a typical rural community without industry, health facilities or any kind of NGO activity. The post-liberation period was a time of euphoria when 'young leaders were thinking with vision and excitement about the possible future of their communities and became eagerly involved with the task of reconstruction after the devastation wrought by the war'[5].

GK, along with other large NGOs such as BRAC[6], was born out of this idealism. Gonoshasthaya Kendra – The People's Health Centre – set out with the key objective of 'health for all'. All projects are interwoven with this basic aim. Concentrating on the poor, GK began by providing preventive and primary health care for the surrounding villages where access to health services was almost non-existent. Over the years, GK has developed into an integrated rural development project which includes education, nutrition, agriculture, environment, vaccine research, herbal medicinal plant research, income generation and vocational training.

Organisational structure

The GK Trust – GK's legal body – consisting of two doctors and two businessmen has a budget of Tk 440 million (US$11 million), about half of which is self-generated. The GK Trust uses the profits from GK's commercial enterprises such as the printing press, the pharmaceutical factory and other businesses to support the non-profit programmes. GK currently employs around 1500 people full-time and about 1000 people part-time and operates in twelve locations (including Savar and Dhaka).

There are five major departments: health, advocacy and education, agriculture, disaster management and credit co-operatives and Nari Kendra. The health section comprises a training division (training of paramedics), the rural health programme and the urban health programme. Nari Kendra deals with vocational training, marketing matters and adult education of the trainees[7].



Dr Zafrullah Chowdhury is Projects Co-ordinator of GK. He is widely regarded as the father of Bangladesh's National Drug Policy, which pioneered more affordable, locally manufactured essential generic drugs. *Picture: One World Action*

3. Gonoshasthaya Kendra's Approaches

Life at GK's Savar centre has involved daily agricultural work for staff at all levels. *Picture: Jenny Matthews*

GK's overall objective is to use primary health care as an entry point to work with the people, for the people, to develop a just society. GK works towards this end by:

- Developing a people-oriented health care system and making people aware of health issues
- Promoting education among the poor, particularly poor women and children
- Establishing women's rights by changing their status in society
- Working with people on their economic emancipation by organising income-generation activities and organising poor people to defend their interests
- Playing an advocacy role to influence policy at the national and international level which will directly and indirectly benefit the poor
- Promoting the mother language, Bangla and the spirit of the liberation war, establishing its importance in national life
- Creating social awareness against fundamentalism and communal violence and protecting the interests of minority communities
- Undertaking natural and man-made disaster relief, rehabilitation and preparedness programmes
- Maintaining a certain level of self-reliance by engaging in more commercial activities to become less dependent on donor money.

The following approaches are adopted by GK to achieve these objectives.

Understanding rural reality

GK aims to create an egalitarian living and working atmosphere amongst its staff as well as understanding and solidarity with villagers and their lifestyle. GK's philosophy is deeply rooted in its history and the visions that people had during the post-liberation period, which explains the high expectations it has of its staff, such as living within the GK community and participating in daily morning agriculture. The agricultural morning work, for example, promotes solidarity throughout the organisation, all staff, including directors, participate in this joint labour. It also encourages understanding

of agricultural concerns and ensures an efficient use of GK's land.

GK applies the founders' philosophy and innovative programmes to rural reality by learning from local knowledge. Through discussions with villagers and observation of local lifestyles GK has learned to design its development activities to fit rural people's time schedules. For example, its work with farmers takes place in the early morning and late afternoon. Paramedics visit people in the villages rather than expecting them to travel to the medical centre and GK uses the Bengali calendar instead of the European one when dealing with villagers.

Grassroots leadership

GK places a strong emphasis on employing people from the grassroots into leadership positions. Staff who are firmly rooted in the villages are an extremely powerful tool for any organisation committed to poverty reduction and development. Most of GK's staff have a lower middle class, rural background and therefore serve as role models for their communities as well as earning GK credibility within those communities.

As GK has grown many of its original staff have been promoted. Many of the early female volunteers have become leading figures in the organisation as managers, training or health co-ordinators or key representatives of the internal GK committees. Others have left to set up their own initiatives in their villages, such as community health centres.

A central concern for GK is making all people who work there feel part of a wider community working for a common purpose.
Picture: One World Action

Communal lifestyle

GK's development approach for working with women is different to that of other NGOs in Bangladesh in that it does not apply the standard 'samiti' method–where women's groups are formed at the village level. In GK's case women come from the surrounding area to live within the organisation. Rather than working with small groups on an individual village level, GK draws women together. Because of this method, collective relationships, solidarity networks and group consciousness are developed within the agency[8].

GK women also encounter men at the organisation. The fact that non-family related men and women work, sit, eat and live together in close proximity on a daily basis is highly unusual and surprises newcomers, particularly rural women.

The organisation's headquarters accommodate a school and day care centre for the workers' children. They also house meeting halls, a hospital offering health and family planning services, a bank and various manual and technical workshops. GK's communal set up is quite unique in Bangladesh. Directors, doctors, staff and workers share a harmonious day-to-day life. Apart from married couples, people live and eat communally and accommodation quality is equal regardless of profession.

Social inclusion

An important aspect of GK's overall policy is its secularism. Muslims and non-Muslims work, eat and live together at GK. They are treated equally and their respective religious festivities are acknowledged and celebrated. GK is actively involved in campaigning against

fundamentalism and communal violence. It stood up for the protection of minority communities during crisis periods in 1990 and 1992 following the Babri mosque incident in India and more recently in 2001 in relation to the violence against Hindu minorities during and after the general election.

GK has also shown a strong commitment to the rights of indigenous peoples in Bangladesh whose land and human rights are continuously violated. GK plans to open 22 new schools in the Chittagong Hill Tracts. These schools will prioritise students from indigenous communities. In order to reinforce the language and culture of indigenous people, teaching will take place in their languages. Local teachers will be recruited from the indigenous population and a curriculum will be designed that relates to their culture, traditions, language and history. It is hoped that in the long run this will lead to wider participation and representation of indigenous people within the national economy[9]. GK has worked with refugees and displaced persons[10] and is one of the few NGOs that stood up against communal riots in 1987 and 1992.

GK offers accommodation to destitute women who have been abandoned by their husbands. During their stay they have access to literacy, vocational and skills training, and a regular income. With money and knowledge they acquire a new sense of self and dignity. Living in a 'family atmosphere' plays an important part in fostering new friendships and mutual support networks between women. Some have gone as far as replacing institutions such as the family and kin by a new institution, where emphasis is placed on relationships between non-relatives. For these women, GK has become a new home giving them a feeling of liberation from old bonds and oppressive lifestyles, and a sense of solidarity with the new family members.

People with physical disabilities have found open doors and new opportunities within GK. Being physically disabled is seen as a curse in a poor country like Bangladesh. The state has no provision for people with disabilities, who are entirely dependent on family members being willing and able to care for them, the only other alternative is begging. At GK, people with disabilities can find both a home and a responsible job providing them with both security and respect.

Gender equality and equity

GK's distinctive working, learning and living environment creates an atmosphere that allows women to develop, to learn from new experiences, and to engage in new collective social relationships. GK's approach towards gender equality and equity combines the improvement of women's material well being with strategies for empowerment. It addresses women's practical as well as strategic needs. A great emphasis is placed on demonstrating to the trainees themselves, and to society at large that women can perform roles other than those traditionally ascribed to them.

For 18 years there has been a creche at GK enabling women to work and study despite the demands of motherhood which would normally have severely restricted their involvement in any activity outside the family. GK women are entitled to six months maternity leave, four months with full pay and two months with half pay, they are also entitled to up to six months extra unpaid maternity leave if they wish. Paternity leave is also given, on the permission of the mother.

GK women are paid through a bank rather than in cash, this not only encourages them to save and make use of bank facilities, it also

"I don't know what it is about the GK women, but in a room full of village women one would immediately recognise who the GK women were."

Farida Akhter, Ubinig, Executive Director

"When someone is sick they ask me what should be done. I give advice and if someone is very sick I advise them to take the patient to the hospital... They say I work at the 'medical', so I must know many things about medicines. I tell everyone about many things so everyone thinks well of me."

Zohra, GK printing press

helps them to keep hold of their earnings, and therefore some degree of autonomy within their families. Traditionally male members of the household have control of the family purse, including the women's earnings. In addition, after four years of working for GK, women have the opportunity to take two years study leave on full pay.

As many women commute between their homes and GK, they have become an active link between the organisation and its communities, offering the latter a service and creating a knock on effect over time. Most women have gained entirely new identities in their villages where they are no longer perceived merely as wives, sisters or daughters of their male family members. For the first time in their lives they are acknowledged for their own sake, as villagers come to them to seek their advice in matters such as family planning, health and nutrition.

Solidarity

At GK women have carved out a space for themselves where they can meet and engage with other women. They have encountered others with whom they can exchange stories and experiences. Consequently a strong sense of solidarity has evolved. The values of solidarity and mutual support that women have nurtured amongst themselves are not confined to the organisation. This becomes evident at times of emergency when predominantly female rescue and relief teams are dispatched to the affected areas. The sacrifices and anxieties of travelling to distant places, often leaving families (including children) behind for weeks on end, are replaced by feelings of pride that they are contributing to saving people's lives.

Social relationships established at GK also form the basis for collective action in pursuit of women's interests. Every year the women take part in the marches during the International Woman's Day. GK members do not perceive their participation merely as a necessary duty, many see marches as an occasion where one speaks, sees and practices equality. Some see the marches as a collective protest against male dominance and violence against women, others go there to 'claim their rights' and to ensure a better future for the next generation.

"Men shouldn't beat or abandon their wives. If we go to these marches and it will not help my generation, it will help at least my daughter's. That is why we need to go there."

Hanufa, GK carpenter

4. GK Programmes

GK applies a combination of strategies towards achieving its goals, which include income generation schemes and consciousness-raising programmes. Whilst for many NGOs active in Bangladesh, micro-credit provision has become a central strategy in recent years, GK has continued to use health as an 'entry point' to mobilising the poor.

Primary health care

The rural health programme

GK's initial focus on purely curative services to the poor was soon modified by the understanding that a person's overall health is conditioned by socio-economic factors. When GK doctors realised that their classical medical education was inappropriate in the context of rural Bangladesh they proposed an entire reorganisation of the existing health system. The focus shifted to primary health care with a holistic approach to health that would emphasise the well-being of a person, not just the absence of disease. For this reason GK began to involve itself in addressing poverty issues such as malnutrition, illiteracy, lack of clean water and poor sanitation.

GK has been a key contributor to thinking about the way health services can be provided in a country with one doctor for every 30,000 people
Women paramedics can bring healthcare direct to the doorstep of the poorest people. *Picture: Jenny Matthews*

Central to GK's primary health care model are its paramedics, who are predominantly young unmarried women from the surrounding villages. The training of these women to become community health workers, which dates back to the early 1970s, is one of GK's most strikingly innovative programmes. Initially, the female paramedics had to face abuse and intimidation largely instigated by the traditional village community leaders as they dared come into villages unveiled, riding a bike (unheard of in those days), and unaccompanied by a male 'protector'. Occasionally they were even thrown out of their homes and villages. Following dialogue with the village heads and a great deal of perseverance, 'GK women' are now well respected in the communities who appreciate health services being delivered directly to their doorstep.

Paramedics have become significant agents of change within their communities, as they speak to rural women directly and address their specific health needs. Health care services spread from house to house with each paramedic covering about 2000 to 4000 family members per month. The paramedic programme is one of GK's biggest achievements, its success reflected in the government's decision to recruit women as family planning field workers and primary school teachers.

The paramedic programme has managed to develop the concept of the 'health team' (female paramedics and indigenous health professionals joining forces with doctors), and also to demystify existing health care models. It has empowered female paramedics to perform minor operations and tubectomies, previously performed only by male doctors.

Bangladesh at present only has one doctor for every 30,000 people. An 'army of paramedics' is more effective in delivering health care and in putting in place preventative measures against the more common diseases such as dysentery, cholera, diarrhoea and scabies. This practice is also more cost-effective as a paramedic's training period is much shorter and at a lower cost than that of a physician.

In short, through their gender and village background, paramedics are best tailored towards meeting local needs, in particular those of women. Sensitised towards village culture, the paramedics, through regular house-to-house visits in the local communities, contribute enormously to rural women's increased utilisation of available services. The GK experience demonstrates clearly how paramedics can become an indispensable link between a community and its health care provider.

Besides Savar there are other programmes in GK's various subcentres, which are spread throughout the country. Overall GK provides health care services to a population of more than 800,000. Domiciliary health care is provided by a 70 bed hospital in Savar with a 24-hour emergency department. The hospital is equipped for pathology tests, X-rays, EKGs and surgery.

Treatment at GK is not free, however. On the basis of a survey conducted in 1972 a health insurance scheme was introduced in order to provide sustainable health care services for the poor. Each patient or family was to pay a monthly subscription, the amount determined by their socio-economic status. People were charged for curative care only, not preventative health care. The aim was to change people's attitudes and encourage them to take more responsibility for illness prevention rather than relying on a cure when illness developed. GK was hoping to encourage co-operative self-help efforts where health care would eventually become a community-financed service provision.

GK made the mistake of expecting the poor to come to them at all times. There were periods when the poor could not afford to pay a subscription fee, regardless of how small it was. GK has come to realise that investing in health care, especially in the form of insurance, is often impractical for the poor. There is a need to explore avenues of popularising the scheme by strengthening local networks, as the concept of risk sharing remains fairly abstract to the poor.

To address this problem, GK is working on developing new campaigns and liaising with garment factory owners, employers of domestic servants and NGOs. One possibility that GK is looking into is co-operating with ASA–a large local micro-credit organisation. One of the benefits of a membership with ASA would be health insurance and health services provided by GK. It is hoped that this initiative could have the effect of increasing the popularity of the insurance scheme amongst the poor.

Quality health services are provided at GK's Dhaka hospital. People are charged according to their ability to pay, or covered by a people-centred Health Insurance Scheme. *Picture: One World Action*

The urban health programme

Increased poverty, land fragmentation and a stagnant rural agricultural market, coupled

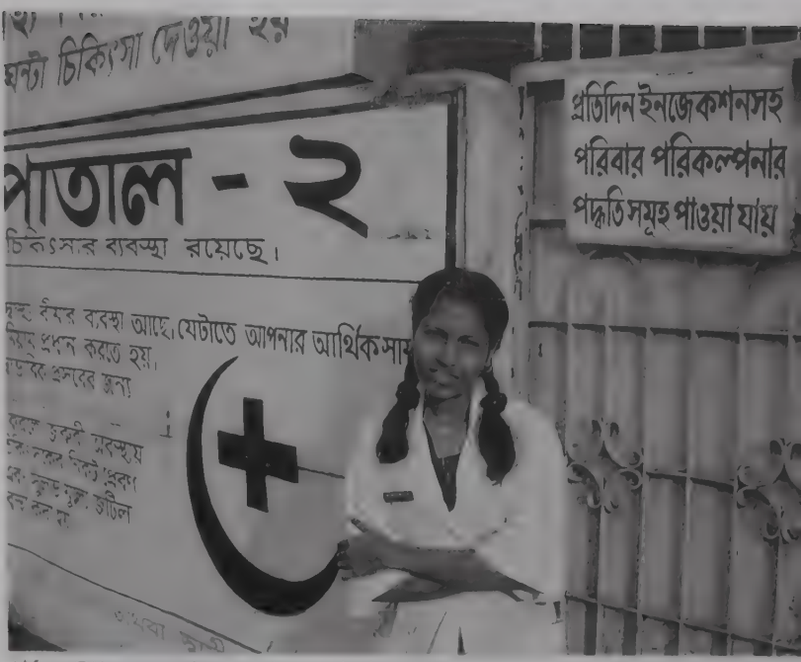
with a rise in employment opportunities in new industries in the urban centres, has led to rapid urbanisation over the last decade. The population of Dhaka, Bangladesh's capital, now exceeds 10 million. Half of the population live in extreme poverty with many rural migrants living in slums, as the city has been unable to provide the necessary infrastructure for the increase in its population. The urban poor lack adequate living conditions, basic health care services, clean drinking water and sanitation.

In 1993 GK initiated its urban health community programme with the aim of improving quality of life for the urban poor. After incidents such as slum eviction and physical harassment by urban gangs forced the early sub-centres to be closed, GK adopted a two-tiered approach with a small static clinic in Mirpur and satellite clinics in key areas. These are run in collaboration with community leaders, partner organisations, factory owners, schools and mosques.

The programme currently operates from 25 satellite spots provided by the community such as a local school or garment factory. Every week GK's services are announced in mosques and other centres. Five medical teams consisting of two to three paramedics visit the slum communities five times a week running one or two sessions a day.

Education plays a major role in the urban health programme and is run in local schools and garment factories. Topics range from prevention of diseases, reproductive rights, children's rights, gender issues to domestic waste disposal and campaigning for acid burn victims.

In 2000 GK opened a plastic surgery unit to treat acid burn patients. Its service included the rehabilitation of acid burn survivors through psychological support and vocational training. In its campaign work GK distributed about 10,000 posters in co-ordination with other organisations.



Alif, a GK paramedic, stands outside the Mirpur clinic where she lives and works. GK opened this clinic on the fringes of slum settlements to make health care available to the women, men and children living there. *Picture: One World Action*

The number of acid attacks, particularly on women, has been increasing over the last few years in all areas of Bangladesh. GK addressed the need for action and awareness raising against acid violence in its own programme in 1999. The main objectives were to inform people about the effects of acids, show them ways to support acid burn victims and to mobilise communities to confront, and treat as criminals, people who carry out acid attacks.

Education Programme

Gonopatshala

Gonopatshala, the People's School, began in 1976 aimed at children, particularly girl children, from landless families, it started with an intake of 50 children and has expanded enormously. Its latest proposal aims to address approximately 7,200 poor children in 43 schools in 13 districts of Bangladesh.

The People's School was developed in response to inadequate national educational facilities, low school attendance and high drop-out rates. Low attendance was strongly related to the state schools' lack of understanding of the needs of the poor. Poor teaching quality, low teacher motivation,

"In the name of education for the poor, the poor are actually being deprived of a chance for further education. GK offers formal education, but in a non-formal way. We have scrutinised the formal education system and made it more flexible. We do not accept parts of the curricula that are anti-people, but we follow the general government text, so that the students have an opportunity to go for further education. Now the poorest family's daughter can go to university"

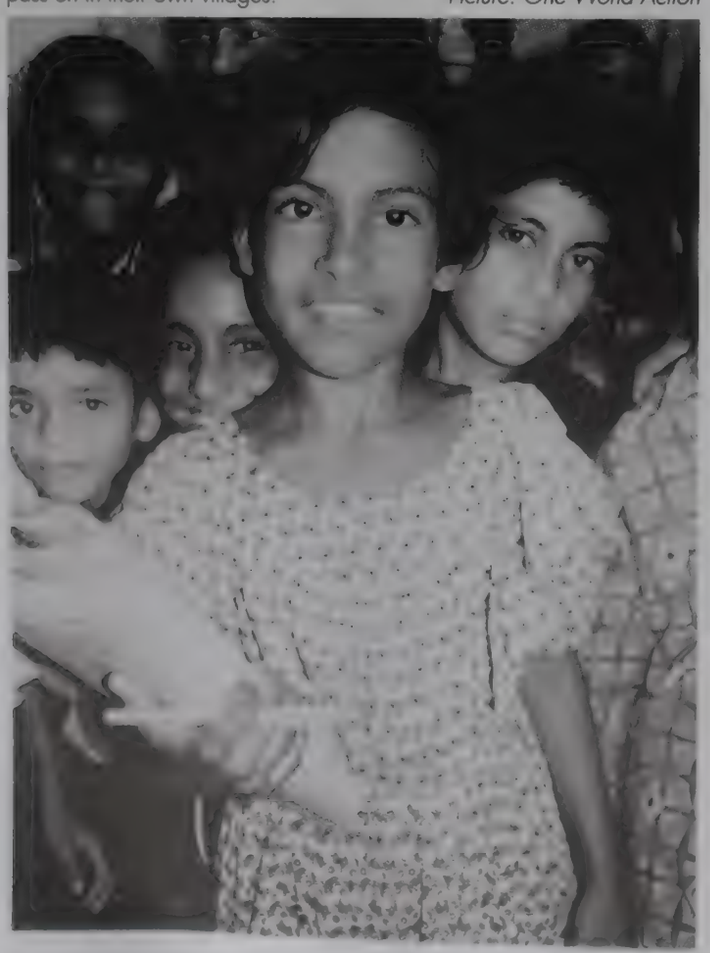
Dr Zafrullah Chowdhury, GK, Projects Co-ordinator

lack of female teachers and inadequate opportunity for community involvement in education together with gender bias limiting girls' access also contributed.

GK's schools offer an alternative approach to primary education. They allow for a flexible time table adjusting to working hours and agricultural work. This enables children to go to school as well as carrying out work for their families. Poor parents depend on their children's labour such as collecting fuel and water, tending livestock or selling goods in the market. At times of planting and harvesting classes work as a group in the fields to help some children complete their tasks so that they may all return to school. Children are allowed to bring their animals to the school premises.

GK schools make no demands on school uniform and provide the children with a slate and pencil. They follow the Montessori system where no homework is required. The curriculum includes relevant life skills such as primary health care, hygiene, sanitation, care of the environment, awareness of one's rights and the wider values of education, which children are encouraged to promote in their villages.

People's Schools give priority to girl students. Children develop life skills such as basic healthcare and nutrition, which they are encouraged to pass on in their own villages. *Picture: One World Action*



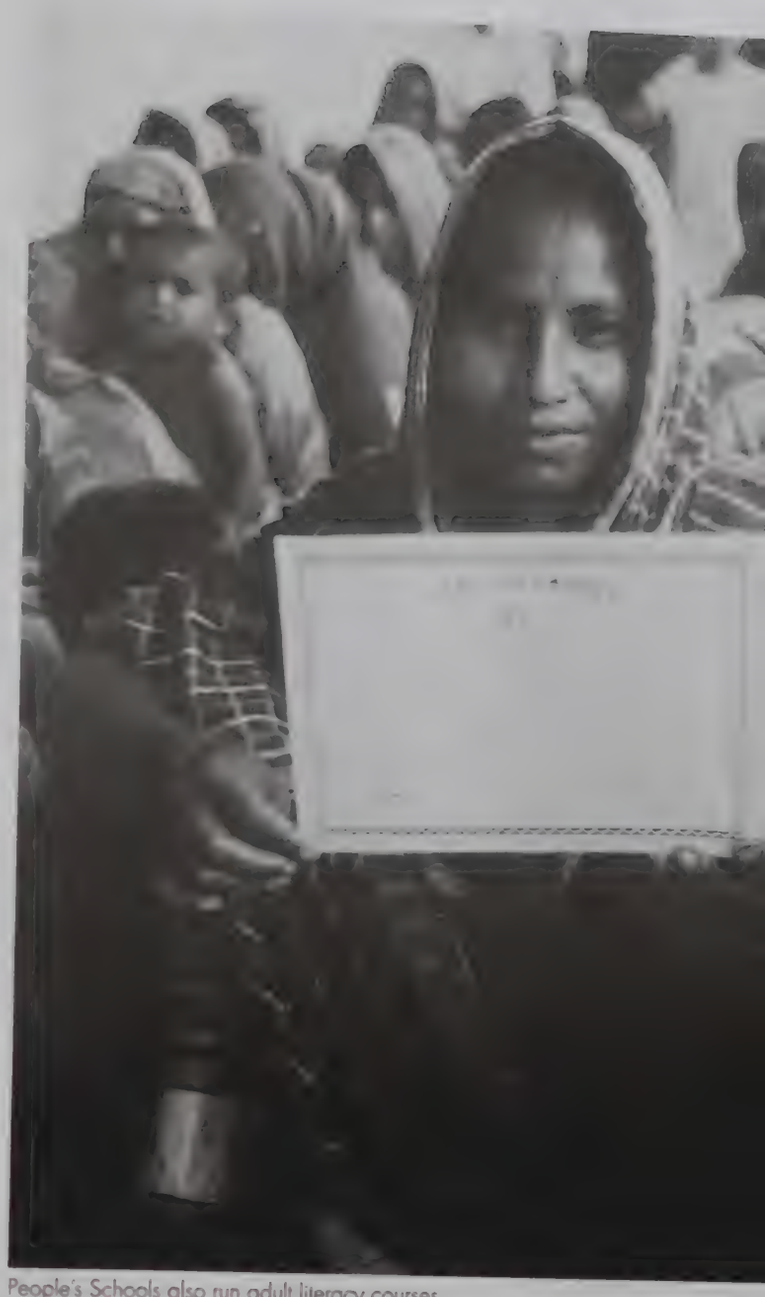
GK's approach to education challenges prejudices, including gender stereotypes. The schools implement a policy of positive discrimination towards girl children. GK invests in appropriate teacher training and aims at recruiting local women as teachers. Teachers maintain a close relationship with parents through regular house visits. The teaching methodology follows a participatory approach, which encourages the involvement of students in decision-making processes. Students become teachers when sharing what they have learned with others from their communities.

School Management Committees enable communities to take responsibility for managing the schools and help develop a sense of ownership. All major decisions are made by these committees, which consist of union council members, village leaders, teachers, parents and pupils. GK is responsible for building the capacity of school management committees to ensure sustainability of the project.

Whilst other NGOs follow an informal model, GK has shifted towards formal education, allowing poor children to gain qualifications and the opportunity to enter higher education.

Gono Bishwabidyalay

Gono Bishwabidyalay–GK's university with a difference–was founded in 1998. It particularly encourages women, students from low-income groups, students whose family members were freedom fighters during the liberation war and students from ethnic minorities to enrol. GK sponsors a number of its own (mainly female) workers and paramedics to pursue further studies at the university. Again, the emphasis is on combining classical teaching methods with participatory approaches that incorporate an understanding of rural life. When needed, students act as health workers or teachers during literacy campaigns. A major objective of the university is to act as a link between established scientific knowledge and 'people's knowledge', which is based on their experiences and socio-economic conditions. Courses offered include both health sciences and social sciences including languages, culture, environment and development.



People's Schools also run adult literacy courses for the student's parents *Picture: One World Action*

Adult education

GK holds regular classes for its workers and trainees with the aim to 'demystify knowledge and make it accessible to more people'[11]. Classes often intersperse vocational and literacy training which has the effect of increasing enthusiasm for learning by providing a 'practical' incentive. For example, GK now arranges combined literacy and sewing classes for women, after an earlier literacy class was poorly attended.

GK's approach to health as part of an integrated development programme targeted at people's basic needs is apparent in the education programme. The adult education programme is seen as providing access to knowledge that goes far beyond literacy and numeracy skills.

"We learn about many things, the body and health... what to do when you grow old, that you should spend your money carefully, save some... They advise us to maintain good health and not have too many children. They ask us to explain it to our husbands. They advise us to drink water from the tube well... They tell us about certain medicines and tell us which injections we need for our children."

Majilla, former GK carpenter

Training Programme

The paramedics programme

GK has trained over 4000 paramedics. Paramedics undergo in-service training for at least six months as medical auxiliaries. Training also includes classes in anatomy, selected topics in physiology, common drugs, and simple pathology. The general responsibilities of a paramedic cover vaccination and immunisation, maintaining birth and death records in their communities, pregnancy care, treatment of common diseases, performance of minor operations and sharing information on public health, hygiene, family planning and nutrition as well as creating social awareness amongst the villagers, especially women.

Nari Kendra – the vocational training centre for women

If the health programme was to have a lasting impact it would first have to guarantee women access to income and education[12]. Nari Kendra, the vocational training centre for rural landless women, was set up in 1973. The aim was to address women's vulnerable position in society, which was hindering their access to health services because they depended on male family members to accompany them to the health centres and because they did not have their own money to spend.

Following an unsuccessful attempt at marketing Jute handicrafts, GK broke with traditional income generation techniques and expanded into new areas of work. From 1976 onwards vocational skills were introduced such as, metalwork (welding, lathe operation and sheet bending), carpentry, shoe-making, construction work, driving, electrical work, plumbing, printing and irrigation pump operation, repair and maintenance. The aim was to address local demand for services rather than try to break into an already saturated tourist market[13].

Recruitment for the vocational training centre has improved over the years reflecting changing attitudes to women's roles. In the early days GK staff had to go to the nearby

Nari Kendra vocational skills training. Challenging perceptions of what is 'appropriate' work for women is a concern at the heart of most of GK's programmes. *Picture: Tanja Haque/One World Action*

GK deliberately deploys a predominantly female relief team during times of crisis and flooding. Special types of survival food have been developed which are then prepared by teams of local people and GK workers.
Picture: Helen O'Connell/One World Action

villages in search of women recruits. From the 1980s onwards, as popularity has increased, more women have come to GK through personal contacts. After 1986 GK expanded its training programme to include services such as driving, electrical work, plumbing and construction work.

The training period usually lasts two years. Every year approximately 100 people are trained on the job. Ninety percent of the participants are women. At Nari Kendra the approach towards training has participatory elements. Members are involved in preparing the training methodologies, the formulation of guidelines and the preparation, monitoring and evaluation of the programme activities.

The idea of the training programme was that once women had reached a sufficiently high level of skill, they should be encouraged to establish production units outside of the main centre, unfortunately this goal has had only limited success so far.

GK's disaster management programme

GK has had enormous experience in conducting relief operations since its inception. It has worked on disaster mitigation of major famines, floods, cyclones and tornadoes, Its organisational strength enabled it to continue work even when its own headquarters were affected–as the Savar headquarters were in the floods of 1988.

Relief activities take the form of basic health care services and food supplies. Health care includes health education, Orsaline preparation, installation of water seal latrines and the use of tube-well water for all purposes. GK also undertakes disaster rehabilitation work such as housing, agricultural rehabilitation, social forestry, reconstruction of schools and the construction of multipurpose cyclone shelters. It also provides people affected by disasters with micro credit opportunities. GK's disaster management programme is an example of a

"I did woodwork like doors and windows for schools. We put a roof to the house, built a few benches. We also repaired some houses. We liked it a lot because we all worked together... [the villagers] cried a lot when we went back to Savar."

Hanufa, carpenter

relief initiative being successfully transformed into a holistic development project well rooted within the cyclone prone coastal areas of Bangladesh.

Reflecting its other work, GK's relief efforts place gender at their core, different food is distributed to men and women, young and old, according to nutritional need and GK deliberately deploys a predominantly female relief team. This ensures that food and medical assistance reaches the women of the affected areas. Women in the areas have the opportunity to approach women in the relief team directly, which is vital given the socially conservative nature of many of the cyclone prone areas. In the beginning GK women workers were not accepted in these areas, but over the years they have managed to inspire many women in coastal areas to participate in the relief programmes. The GK women express a strong feeling of solidarity with the flood victims, especially the women.

Cyclone shelter schools are built on stilts so they can withstand even heavy flooding during the cyclone season, this makes them doubly useful for local communities. *Picture: Andy Rutherford/One World Action*

GK's relief and rehabilitation programmes thrive on strong community participation and co-operation. This has been possible because GK maintains a policy of respecting and adopting existing community knowledge. GK's flood relief activities provide a particularly good example of this innovative approach. GK has introduced special types of survival food such as hand made chapatis and a balanced food mix as a post flood relief item.

With the benefit of local knowledge, consideration is given to which foods can be consumed hygienically in flooded conditions and nutritional concerns as well as the likelihood of different food types being seized and stockpiled by influential figures within the community. As a result, GK blended food has gained popularity amongst people in affected areas and has been distributed by international NGOs in the region.

Even the policy of issuing return home packs in Jute bio-degradable bags as opposed to plastic, and offering food incentives for the collection of plastic has implications for the severity of future floods. The huge number of plastic bags, together with inadequate refuse collection, can cause major drainage problems in urban areas[14].

5. Political Involvement and Advocacy

Strengthening parliamentary democracy

The approach to political empowerment adopted by other NGOs in Bangladesh centres around the formation of village groups, who are then drawn together in federations. These federations have so far managed to gain only limited influence beyond the local level. The influence of people and their organisations on union/thana and national government structures remain fairly limited[15].

GK's approach towards increased democratisation is innovative in the sense that it does not focus solely on training sessions or voter education programmes, but instead facilitates direct interaction between people and national decision-makers. As in many of GK's programmes the emphasis is on experimenting with innovative ideas, which can then be expanded on and shared with others. During the parliamentary election of 1996 GK initiated and organised 'mukho mukhi' (face to face) meetings between parliamentary candidates and the general public. The aim was to create space for a critical dialogue between the candidates and their potential voters. Parliamentary candidates were invited to explain their manifesto in those meetings and give people the opportunity to ask questions. These meetings shed light on people's ideas and knowledge of the parliamentary system and the expectations they had of the parliament members. The issue of accountability of parliament members towards the people of their constituencies was also raised.

The success of these meetings encouraged GK to pursue its efforts in bringing disadvantaged and marginalised groups into the mainstream of institutional politics. In 1997, three workshops were held in the Chittagong division. 2000 people participated, nearly three quarters of them women. Participants were mostly poor people with low levels of education and included representatives of ethnic minorities. Special efforts were made to familiarise participants with the system of parliamentary democracy in Bangladesh by keeping the language accessible and by using local dialects. The emphasis was on mutual learning. Representatives from local NGOs acted as moderators.

The workshops combined focus group discussions with participatory observation. Simulated 'parliaments' were held to present an image of parliament to people who have little or no access to mass media, they produced a range of recommendations to ensure accountability and bring about transparency in the process of governance.

Major recommendations were that parliamentary seats should correspond to the number of thanas and that there should be an increase in the parliamentary seats reserved for women and members of ethnic minorities. It was also felt that Members of parliament should play a more active role in the delivery of development assistance to rural people and should co-ordinate disaster management activities. There was strong support for the idea that each Member of Parliament should have an office in his or her constituency. Members of Parliament should then visit the constituency for a number of days every month to learn about local issues and to keep their constituencies informed about their activities in parliament. In these ways local and indigenous knowledge should feed into formal knowledge.

Another aspect of GK's initiative towards strengthening democracy is its co-operative relationship with the women union council representatives. During the 1997 union council

elections women were directly elected for the first time. Hence significant new roles emerged for the local representatives and GK held various workshops to provide these women with the necessary training to face future challenges.

Union council representatives participate regularly in quarterly village committee meetings held throughout GK's working area. GK presents a health report to each meeting explaining its activities in each particular area, the income it gained and its expenditures. In this way, the union council members gain an insight into GK's performance and accounts and also gain acceptance in their working area as villagers see them linked to a well-known organisation. GK profits from this co-operation by being regularly updated on the current situation of the respective unions. At present GK is co-operating with approximately 80 women union council members in this way.

The drug and health policies

GK plays a leading role in influencing national health and drug policies[16]. In the early 1970s GK began highlighting unethical practices by drug companies and informing the general public of the 'flooding of Third World markets with inappropriate and harmful drugs'[17]. In 1982, after years of campaigning, the National Drug Policy was formulated. Dr Zafrullah Chowdhury was part of the Expert Committee which undertook an evaluation of all drugs in Bangladesh. In all 1,742 drugs were found to be harmful or ineffective and were to be banned.

In 1979 GK was granted permission to establish Gonoshasthaya Pharmaceuticals Limited (GPL). The idea behind GPL was to produce high quality, low cost, essential drugs. It was also the first factory of its kind to offer many new job opportunities to women. In June 1981 the pharmaceutical factory began producing drugs at very competitive prices, forcing multinationals to cut their prices. As a result of tighter regulation of the multinational pharmaceutical companies, increased local production of essential drugs was encouraged. Prices dropped in real terms, making essential medicines available and more affordable to the poor. It is estimated that the country has saved approximately US$60 million a year in foreign exchange on imported medicines[18]

Though the National Drugs Policy was considered a significant initiative by academics and health activists, the Bangladesh Medical Association (BMA) and some NGOs and TNCs in Bangladesh opposed the policy.

In 1984 Gonoshasthaya Pharmaceuticals was attacked leaving 84 workers severely injured. The residential houses of senior managers and workers of GK and GPL were also attacked. Support from local villagers was essential and the factory was able to continue to operate. Every night for two months hundreds of villagers guarded the GPL factory and GK.

In 1987 GK was central to the formulation of the National Health Policy (NHP). The proposed policy guaranteed access to basic health care to every citizen regardless of where they lived or their income. Primary health care was to be means tested but the poorest people were guaranteed free care. Everybody would have access to secondary

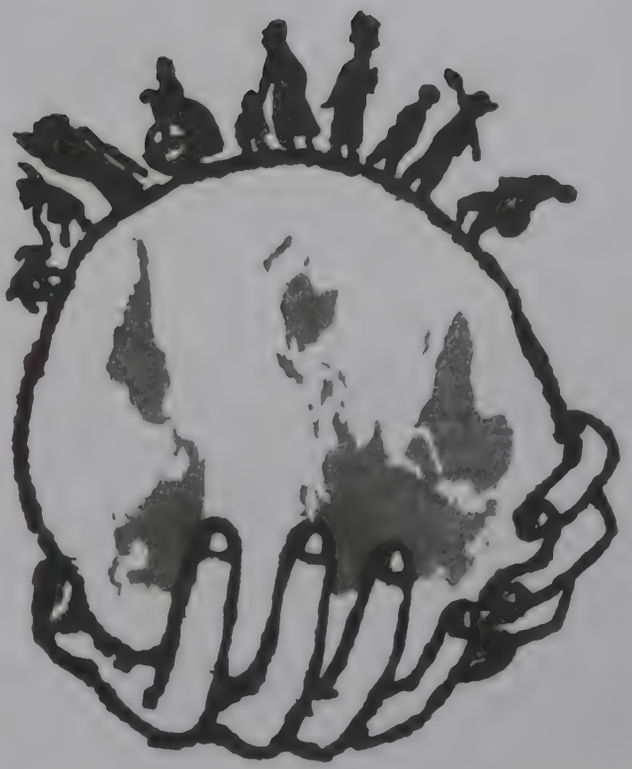
A pathology lab at GK's Dhaka hospital *Picture: One World Action*

and tertiary care through a referral system. Investment in health was to be increased from 2.5% to 10% of the national budget in phases over five years. The whole health care system was to be decentralised and devolved with the creation of sub-district, district, and regional authorities. Systems were to be put in place to make sure that 50% of health representatives were women. Physicians, nurses and health technicians would also have representation. The chairperson of the health authority was to be an elected representative to replace the existing bureaucratic and unaccountable system.

The proposed policy had huge public support, but struck a raw nerve with many doctors who were to be barred from unhindered private practice, and with bureaucrats unused to having to account for their actions to the people and their elected representatives. In 1990 the government accepted the proposed National Health Policy in totality and it passed through parliament. The BMA, TNCs and political parties opposed the new policy.

The city office of GPL was subjected to an arson attack resulting in damage to the building and the destruction of six vehicles, as well as raw materials. There was also an attempt to organise a boycott of GPL drugs. Following the fall of the Jatiya Party government, an interim government was formed and the first casualty was the National Health Policy. An investigation into GK's activities was instigated by the Health Ministry, ostensibly for alleged corruption. The investigation committee, composed of the Auditor General, Director General of Anti-Corruption, Director General of NGO Affairs Bureau and a sitting Judge, and headed by a senior secretary of the government, found that all the 17 allegations made were baseless.

Throughout this difficult period GK, with the full support of the communities with which it works, was successful in defending itself and its work.



The People's Health Assembly Logo

Health for all

GK has also engaged itself in the international 'Health for All' campaign targeted at national and international policy makers and aimed at securing the promises made by members of the World Health Organisation and UNICEF at the Alma Ata conference in 1978. 'Health for all by the year 2000' had been promised but never delivered.

On a global level World Trade Organisation-initiated economic liberalisation, privatisation and commercialisation of health services has led to an increasing gap between rich and poor, both between and within countries. Economic reform policies have increased pressure on governments to decrease their participation and commitment to universal health policies. This has resulted in a shift from implementing comprehensive primary health care towards a 'targeted' approach to health. Many see the 'de-politicisation' of the health movement as an 'attempt to use a few chosen technologies to improve statistics in health while maintaining the social inequalities of the status quo'[19].

As national services have deteriorated, the private health sector has flourished. Large numbers of people have been left with little or no access to health care. In short, health services have become less accessible, more unevenly distributed and less appropriate.

The governments and international organisations responsible for the 'Health for All by the year 2000' declaration of Alma Ata made no attempt to mark their failure in realising their promises or announce a renewed effort as 2000 approached. In contrast, GK hosted the first international conference of the new People's Health Assembly (which evolved into the People's Health Movement) in Savar in December 2000. The People's Health Assembly brought together an international multi-sectoral collective of people and groups campaigning for the implementation of the 'Health for All' promises. Nearly fifteen hundred delegates from 92 countries participated and discussed basic issues of people's health, obstacles to achieving health for all and ways forward. Participants included grassroots health workers, NGOs and activists as well as members of the World Health Organisation, the World Bank and government representatives. The Peoples Charter for Health, which was agreed at the Assembly, has since been distributed and become a valuable advocacy tool worldwide.

GK is lobbying at national level with representatives of both the Awami League and the BNP. Both parties have reacted positively to the initiative. The PHM Secretariat, which is currently based at GK, has opened dialogue with both the Prime Minister and the Leader of the Opposition Party to consider the recommendations.

6. Conclusion: Challenges and Achievements

Challenges

As detailed above, GK has inevitably encountered opposition from those with a vested interest in maintaining the status quo in the Bangladesh health sector and from some large donors. This is due to its emphasis on self-sufficiency and opposition to paternalistic programmes which, designed and conceived abroad, often take little account of local situations with sometimes damaging consequences.

More recently, the objective of self-reliance has become one of the main challenges facing GK. The health insurance scheme and the various businesses were developed in order to provide funds for the running costs of the health programme and the other services and development programmes. Whilst some of the businesses are making small profits, others such as the pharmaceutical factory, are currently making a loss and therefore receiving loans from the GK Trust and Bank. It is vital that GK finds a viable way of balancing its service and development programmes with its businesses, even more so in the light of the organisation's ongoing process of scaling up.

Scaling up is also causing problems due to the extremely high demands it places on staff. The fact that staff are obliged to live on the GK campus means that they can be called to work in any emergency, stretching working hours. This has led to difficulties in finding enough high-quality senior and mid-level staff to service its expansion of programmes and locations. There is a perceived gap in commitment between older staff and new recruits and staff retention is becoming a problem as paramedic workers are recruited by foreign NGOs and private clinics. In order to overcome the general staff shortage GK is now encouraging its paramedics and junior level staff to participate in higher education studies. It is thereby hoped to develop new leadership capacities so that current staff can then be promoted to higher posts. GK is also trying to make officials of externally financed health programmes aware of the impact their programmes have on GK. One idea is for GK to become a capacity building partner for these agencies who would pay GK to provide the necessary human resources training.

Lessons

GK has always been willing to experiment with innovative and challenging projects. When testing its new and at times controversial ideas GK has undergone a continuous process of self-monitoring and assessment. It has also needed to learn from its mistakes and have the courage to start projects over again if they aren't working.

GK's textile factory at Tangail. Like the pharmaceutical factory at Savar, it provides an important means of diversifying income for local women. *Picture: One World Action*

A major element of its learning process has been consultation with villagers. Central to GK's philosophy is the belief that the best training must be combined with knowledge of local life. GK gains credibility and acceptance locally from the fact that most of its staff members come from the grassroots. This becomes an invaluable asset for any organisation claiming to work in the field of poverty alleviation, as staff must be approachable and accessible to the poor.

In its education and training programmes, GK has made knowledge accessible and relevant to peoples lives. This has been achieved by encouraging people to gain their own experience while they are learning, working, living and communicating with others. People, particularly women, are encouraged to share what they learn within their home communities. Gender is mainstreamed within GK's education programmes with the aim of building women's confidence, to encourage them to believe in their own potential.

GK has challenged the myths and misinterpretations surrounding appropriate roles for women in Bangladesh society. In the paramedic and Nari Kendra programmes, GK has created a vehicle through which many women have consciously moved from private into public spaces. In doing so they have made significant steps towards greater equality and GK has contributed to a significant change in Bangladesh's rural landscape.

GK has given women the opportunity to meet people from different backgrounds and regions by providing room for social interaction. The organisation has placed a strong emphasis on collective social relationships meaning that women have developed friendship and trust with other women and learned through the exchange of experiences. This lays the foundation for a sense of solidarity, unity and belonging. Central to GK's ethos is the belief that building solidarity amongst the poor is a pre-condition for any strategy envisioning collective action and social change.

GK has always combined practical work with lobbying in order to influence national and international thinking. One of the best examples of GK's lobbying work is its success in influencing the government to adopt a more affordable health strategy and implement the National Drug Policy. This was achieved despite considerable opposition from the international pharmaceutical industry. The policy was influential in shaping other countries' health policies. Through the efforts of the People's Health Movement GK continues to challenge influential global institutions as it joins the international scene in the campaign for better health for all.

GK has overcome many challenges in the past and will continue to do so. With its many and varied programmes, it remains one of the most exciting and innovative organisations in Bangladesh. Its 30 years of experience in grassroots development has contributed enormously not only in the field of basic service provision, but also in areas such as people's empowerment, gender equality and equity, democratisation processes and advocacy.

Annex: Major Events and Programmes in GK

1972

Establishment of Gonoshasthaya Kendra in Savar
Integrated health and family planning programme begins

1973

Establishment of the women's centre: Nari Kendra
Agricultural work in the mornings begins
Soy bean cultivation initiative and use of soya milk
Training of Community Health Workers (Paramedics) begins
Introduction of Oral Re-hydration Therapy (ORT) at the household level in Savar
Anti-smoking campaign begins, decision is taken not to recruit smokers

1974

Introduction of female sterilisation by female paramedics (first time in Bangladesh)
Gonopatshala: non-formal basic school for poor children begins
Advanced training of female paramedics including bicycle training begins
Relief programmes in famine affected areas of Bangladesh
Awarded Swedish Youth Peace Prize

1975

Establishment of sub-centres and Bhatshala GK
Micro credit programme in Savar area starts
'Tubectomy by Paraprofessional Surgeons in Rural Bangladesh' is published as the lead article in *The Lancet* 27 September issue

1976

The Paramedic Nizam is murdered
Expansion of the women's centre to include non-traditional skills: the metal workshop opens

1977

Training of BRDB women co-operatives on primary health care begins
Tour of Dhaka from Savar by 22 female paramedics by bicycle
Practical training to medical students on community medicine begins
Awarded 'Independence Day Award' for community health and family planning

1978

Setting up of further workshops at Nari Kendra:
Community carpentry and shoe-making begins
Community school begins
Community publication: Gonoprokashani
Community handloom in Sherpur: Gono Tant opens
Rohinga refugee relief programme in Cox's Bazar

1979

Community bakery opens

GK elected as member of the Women's Development Commission of the Government of Bangladesh

1980

Community printing press begins: Gonomudran

1981

Establishment of Gonoshasthaya Pharmaceuticals

1982

GK has large role in formulation of the National Drug Policy

Production of jute-plastic begins

Bangladesh Medical Association (BMA) and Bangladesh Ousadh Silpa Samity (Pharmaceuticals Manufacturers Association) starts campaign against GK and GPL

1983

More sub-centres opened

1984

Creche on GK campus opened

Block printing begins

Gonoshasthaya medicinal plants research centre opens

1985

Relief programme in cyclone affected areas

Burial of dead bodies introduced as part of public health and relief programmes

Driving training centre for rural women

1987

Innovative disaster management methods introduced

Relief for cyclone and tidal bore victims in Satkhira District

1988

Gonoshasthaya bricks: employment programme for rural men and women begins

Antibiotics raw materials production for Gonoshasthaya begins

Flood relief and rehabilitation programme

1989

Tornado relief in Saturia Manikganj

1990

Attempt to draw up a pro-people National Health Policy infuriates the medical profession

Collapse of Ershad government, investigation against GK commences BMA cancels Dr Zafrullah Chowdhury's membership

Interim government cancels grant allocation for Medical college and proposed National Health Policy

ADAB (Association of Development Agencies in Bangladesh) cancels GK's membership

Medical relief for earthquake victims in Iran

Tongi Tornado relief programme

1991

Post-cyclone relief in Cox's Bazar
Diarrhoea prevention programme at Barguna

1992

Relief programme in Rohingya refugee camp in Cox's Bazar (continues until end of 1995)
Post-cyclone rehabilitation programme
Construction of schools and cyclone shelters
Social forestry programme begins
Credit based rural housing
Gonoshasthaya vaccine research and microbiology laboratory opens
Relief work for communal violence victims
North Bengal flood relief programme

1993

Gonoshasthaya urban hospital in Dhaka opens
Cox's Bazar GK opens

1994

Gonoshasthaya Foods ltd begins
Gonoshasthaya Vitaminerals ltd begins
Cyclone relief in Cox's Bazar and Banderban district

1995

Medical aid for malaria affected area in Sylet and Netrokona district

1996

Tornado relief in Tangail and Jamalpur

1997

Cyclone relief in Cox's Bazar
Flood relief in North Bengal

1998

Gono Bishwabidyalay (Peoples University) opens
Flood relief in 10 districts of Bangladesh

1999

Gonoshasthaya Grameen Textile ltd begins
Cyclone relief in Urissa, India
Relief programme in Bombay, India

2000

People's Health Assembly held at Savar GK
Mirpur health centre for urban slums opens
Tornado relief work in Quzlpur
Flood relief in Jessore, Sathkhira

2001

Mirpur health education programme for non-Bengali slum children begins

Notes

1 'Landlessness' is defined by NGOs to include the group of functionally landless, who own a marginal amount of land below 0.5 acres. More than half the rural population falls under this category.

2 For more information on this issue, see *Pesticide Action Network Asia and Pacific* (2001).

3 *United Nations Development Programme Report on Human Development in Bangladesh: Empowerment of Women*, UNDP Dhaka (1994)

4 Ray, J.K. *Organising Villagers for Self-Reliance: A Study of Gonoshasthaya Kendra in Bangladesh*, Orient Longman, Calcutta (1986)

5 White, S.C. 'Evaluating the Impact of NGOs in Rural Poverty Alleviation. Bangladesh Country Study', Overseas Development Institute (ODI) Working Paper 50, ODI, London (1991)

6 The Bangladesh Rural Advancement Committee

7 The metal, jute-plastic and carpentry workshops and GK's security guards fall under the construction section. For these vocations the head of Nari Kendra works together with the head of the construction department. Each training and production unit of the vocational training centre is managed by a production unit head, assisted by skilled workers. Trainers are responsible for both training and production of the units.

8 For a more detailed discussion on women's empowerment experiences and the formation of collective relationships at GK see Haque (2000, 2002).

9 GK plans to open 22 new schools in the Chittagong Hill Tracts that will prioritise students from indigenous communities. Teaching will take place in their own languages, teachers will be recruited from the indigenous population and a curriculum will be designed that relates to their culture, traditions, language and history.

10 For example Rohingya Muslim refugees from the Arakan state of Myanmar, who entered into Cox's Bazar and the Hill Districts in 1992. GK was responsible for the construction of shelters, field hospitals, health and nutrition, water and sanitation and afforestation of half of the existing 12 camps covering a refugee population of 56,000. GK ran this refugee programme from 1992 to 1995–reflecting its capacity for long as well as short-term relief work.

11 *Gonoshasthaya Kendra Evaluation Report*, Savar. (1986)

12 Highlighting this bleak picture, the health centre was confronted in its early days by several attempted suicides by village women who could no longer cope with oppressive marriages.

13 Savar had a serious lack of skilled labourers during that time as many had migrated to the Middle East.

14 For more information see *A Report on 1998 Flood Relief Activities of Gonoshasthaya Kendra and Partners*, Gonoshasthaya Kendra, Dhaka (1998).

15 Thornton, P. et al *Partners in Development–A Review of big NGOs in Bangladesh*, DFID, London (2000).

16 For a detailed description of GK's role in Bangladesh's National Drug Policy see Chowdhury (1995).

17 According to John Madeley, the author of *Big Business, Poor People*, it is unlikely that Bangladesh could have introduced such a policy had the WTO rules applied in 1982 (Madeley, 1999).

18 Chowdhury, Dr Z. *The Politics of Essential Drugs: The Makings of a Successful Health Strategy: Lessons from Bangladesh*, ZED, London and New Jersey (1995).

19 Chowdhury, Dr Q. 'The People's Health Assembly', *LINK* Bulletin of Asian Community Health Action Network 18(1).(2001)

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ONE WORLD ACTION

FOR A JUST AND EQUAL WORLD

One World Action
Bradley's Close
White Lion Street
London
N1 9PF

Tel: +44 (0)20 7833 4075
Fax: +44 (0)20 7833 4102
Email: owa@oneworldaction.org
Web: www.oneworldaction.org

Registered Charity No. 1022298

Gonoshasthaya Kendra
City Office
House No. 14 E
Road No. 6
Dhanmondi
Dhaka-1205
Bangladesh

Tel: 00 880 2 8617208
Fax: 00 880 2 8613567
Email: gk@citechco.net

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